		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0011650

Facility Name: Good Samaritan Care Center

Address: 2299 Metropolis St. (Number) Metropolis, IL (City) 62960-1393 (Zip Code)

County: Massac

Telephone Number: (618) 524-2634 **Fax #** (618) 524-2507

IDPA ID Number: 37-0859225001

Date of Initial License for Current Owners: 01/01/65

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501C(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mark A. Hull, CPA **Telephone Number:** (219) 239-7883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Grant Shumway
(Title) CEO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Scott E. Martin, CPA
Crowe Chizek & Co. LLP
(Firm Name & Address) 330 E. Jefferson Blvd. PO Box 7
South Bend, IN 46624
(Telephone) (219) 232-3992 Fax # (219) 236-8692

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	94	Skilled (SNF)	94	34,404	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	94	TOTALS	94	34,404	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,961	136	1,913	4,010	8
9	SNF/PED					9
10	ICF	20,292	5,889		26,181	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,253	6,025	1,913	30,191	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.75%

D. How many bed-hold days during this year were paid by Public Aid?
219 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/65

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 1,748

Medicare Intermediary AdminaStar Federal - Kentucky

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	143,264	14,901	5,501	163,666		163,666		163,666			1
2	Food Purchase		139,543		139,543		139,543	(8,920)	130,623			2
3	Housekeeping	52,083	12,094		64,177		64,177		64,177			3
4	Laundry	36,747	6,493		43,240		43,240		43,240			4
5	Heat and Other Utilities			70,446	70,446		70,446		70,446			5
6	Maintenance	42,354	2,505	58,200	103,059		103,059		103,059			6
7	Other (specify):*											7
8	**TOTAL General Services**	274,448	175,536	134,147	584,131		584,131	(8,920)	575,211			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	909,824	33,947	19,278	963,049		963,049		963,049			10
10a	Therapy	29,587	3,723	71,104	104,414		104,414		104,414			10a
11	Activities	23,139	4,746	8,384	36,269		36,269		36,269			11
12	Social Services	48,084	321	1,440	49,845		49,845		49,845			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,010,634	42,737	100,206	1,153,577		1,153,577		1,153,577			16
	C. General Administration											
17	Administrative	37,175		132,458	169,633		169,633		169,633			17
18	Directors Fees											18
19	Professional Services			164,585	164,585		164,585	(150,504)	14,081			19
20	Dues, Fees, Subscriptions & Promotions			23,251	23,251		23,251	(1,983)	21,268			20
21	Clerical & General Office Expenses	93,954	8,037	23,620	125,611		125,611	(5,956)	119,655			21
22	Employee Benefits & Payroll Taxes			248,389	248,389		248,389		248,389			22
23	Inservice Training & Education			2,140	2,140		2,140		2,140			23
24	Travel and Seminar			4,605	4,605		4,605		4,605			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			24,550	24,550		24,550		24,550			26
27	Other (specify):* **Contracted Admin.**			5,325	5,325		5,325		5,325			27
28	**TOTAL General Administration**	131,129	8,037	628,923	768,089		768,089	(158,443)	609,646			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,416,211	226,310	863,276	2,505,797		2,505,797	(167,363)	2,338,434			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Good Samaritan Care Center #0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			136,737	136,737		136,737		136,737			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			197,024	197,024		197,024	(2,207)	194,817			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			9,992	9,992		9,992		9,992			34
35	Rent-Equipment & Vehicles			14,773	14,773		14,773		14,773			35
36	Other (specify):*											36
37	**TOTAL Ownership**			358,526	358,526		358,526	(2,207)	356,319			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,807	6,600	32,407		32,407		32,407			39
40	Barber and Beauty Shops			6,887	6,887		6,887		6,887			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,606	51,606		51,606		51,606			42
43	Other (specify):* **Resd Rel. Admin**			374	374		374		374			43
44	**TOTAL Special Cost Centers**		25,807	65,467	91,274		91,274		91,274			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,416,211	252,117	1,287,269	2,955,597		2,955,597	(169,570)	2,786,027			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,782)	2		4
5	Telephone, TV & Radio in Resident Rooms	(34)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,207)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(138)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(150,504)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,922)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,983)	20		28
29	Other-Attach Schedule Salary Mktg Dir	(45,467)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (215,037)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (215,037)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops	X		6,887	40	41
42	Laboratory and Radiology	X		2,276	39	42
43	Prescription Drugs	X		30,131	39	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 39,294		47

STATE OF ILLINOIS

Good Samaritan Care Center

ID# 0011650

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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30				30
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41				41
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66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Good Samaritan Care Center **#** 0011650 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,920)	0	0	0	0	0	0	0	0	0	0	(8,920)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,920)	0	0	0	0	0	0	0	0	0	0	(8,920)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(150,504)	0	0	0	0	0	0	0	0	0	0	(150,504)	19
20	Fees, Subscriptions & Promotions	(1,983)	0	0	0	0	0	0	0	0	0	0	(1,983)	20
21	Clerical & General Office Expenses	(5,956)	0	0	0	0	0	0	0	0	0	0	(5,956)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(158,443)	0	0	0	0	0	0	0	0	0	0	(158,443)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(167,363)	0	0	0	0	0	0	0	0	0	0	(167,363)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Good Samaritan Care Center **#** 0011650 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,207)	0	0	0	0	0	0	0	0	0	0	(2,207)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,207)	0	0	0	0	0	0	0	0	0	0	(2,207)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(169,570)	0	0	0	0	0	0	0	0	0	0	(169,570)	45

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
American Lutheran Welfare Society	100%	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Land rental	$ 9,992	Member of the Board of Directors	0.00%	$ 9,992	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 9,992			$ 9,992	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National State Bank		X	Mortgage	$5,252.63	3/9/94	$ 380,000	$ 298,931	3/1/04	8.75%	$ 17,406	1
2	National State Bank		X	Construction (Line of Credit)	Interest Only	9/12/96	1,900,000	1,689,945		6.25%	105,727	2
3	National State Bank		X	Construction Equipment	Interest Only	9/1/96	262,000	260,359		6.25%	15,894	3
4	National State Bank		X	Construction (Line of Credit)	Interest Only	3/1/99	550,000	470,277		6.25%	29,738	4
5												5
	Working Capital											
6	National State Bank		X	Working Capital	Interest Only	6/9/95	100,000	99,852	Yearly	6.25%	6,095	6
7	National State Bank		X	Working Capital	Interest Only	3/1/98	350,000	349,153	Yearly	6.25%	22,164	7
8												8
9	TOTAL Facility Related				$5,252.63		$ 3,542,000	$ 3,168,517			$ 197,024	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,542,000	$ 3,168,517			$ 197,024	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Good Samaritan Care Center **#** 0011650 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	N/A	8
1996	99	9
1997	42	10
1998	47	11
1999	50	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,793 B. General Construction Type: Exterior Brick Frame Brick, Block & Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	50		1965	1965	$ 359,848	$ 8,996	40	$ 8,996	$	$ 323,856	4
5	35		1974	1974	312,514	7,812	40	7,812		210,924	5
6	9		1999	1999	2,463,958	82,132	30	82,132		82,132	6
7											7
8											8
	Improvement Type**										
9	Building & Land Improvements			1979	10,334		Various			10,307	9
10				1981	15,080	213		213		11,696	10
11				1982	43,823	1,662		1,662		40,856	11
12				1983	11,019	321		321		11,506	12
13				1984	46,462	284		284		45,469	13
14				1985	27,731	1,317		1,317		22,311	14
15				1986	7,415					7,415	15
16				1987	10,676	406		406		9,333	16
17				1988	8,822	724		724		8,990	17
18				1989	4,057	341		341		3,863	18
19				1990	13,903	1,127		1,127		11,892	19
20				1991	15,453	1,593		1,593		14,838	20
21				1992	5,234	523		523		4,592	21
22				1993	9,930	993		993		7,295	22
23				1994	10,981	1,263		1,263		8,497	23
24	Circulating Pump			1996	2,470	247		247		1,177	24
25	Curtains/Mini Blinds			1996	2,945	295		295		1,406	25
26	Bell & Gossett Pump			1997	3,224	393		393		1,572	26
27	Carpet and Painting			1997	1,250	83		83		83	27
28	300 Hall Heating Units and Chiller			1997	2,555	170		170		170	28
29	Repair Washer			1997	726	48		48		48	29
30	Carpet			1998	418	28		28		28	30
31	Door Alarms			1998	4,000	267		267		267	31
32	Building Improvements			1998	7,131	475		475		475	32
33	New Fence			1999	520	35		35		35	33
34	Air Conditioning Condensing Unit			1999	3,085	206		206		206	34
35											35
36	TOTAL (lines 4 thru 35)				$ 3,405,564	$ 111,954		$ 111,954	$	$ 841,239	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cubicle curtains			1999	3,589	239	15	239		239	9
10	Cubicle curtains			1999	1,255	84	15	84		84	10
11	Fire alarm system			1999	16,500	1,100	15	1,100		1,100	11
12	Hydraulic system			1999	2,498	167	15	167		167	12
13	Nurse call system			1999	13,310	887	15	887		887	13
14	Nurse call system			1999	33,040	2,203	15	2,203		2,203	14
15	Parralel bars			1999	324	22	15	22		22	15
16	Phone system			1999	11,346	756	15	756		756	16
17	Pump system			1999	2,687	179	15	179		179	17
18	Signs for building			1999	1,072	71	15	71		71	18
19	Stove			1999	2,615	174	15	174		174	19
20	Therapy pool			1999	3,399	227	15	227		227	20
21	Therapy pool			1999	3,635	242	15	242		242	21
22	Therapy pool			1999	4,631	309	15	309		309	22
23	Therapy pool			1999	40,848	2,723	15	2,723		2,723	23
24	Washer			1999	5,959	397	15	397		397	24
25	Closet Doors			2000	2,548	170	15	170		170	25
26	Air conditioner compressor			2000	2,212	147	15	147		147	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 151,468	$ 10,098		$ 10,098	$	$ 10,098	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 202,896	$ 14,685	$ 14,685	$		$ 155,819	37
38	Current Year Purchases	6,235						38
39	Fully Depreciated Assets	119,415					119,415	39
40								40
41	TOTALS	$ 328,546	$ 14,685	$ 14,685	$		$ 275,234	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportation	1987 Ford Van	1995	$ 5,600	$ 0	$ 0	$	3	$ 5,600	42
43	Patient Transportation	Wheelchair Lift	1995	4,684	0	0		5	4,684	43
44										44
45										45
46	TOTALS			$ 10,284	$	$	$		$ 10,284	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,895,862	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 136,737	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 136,737	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,136,855	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Barber & Beauty Equipment	$ 3,440	$	$ 3,440	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 3,440	$	$ 3,440	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 14,773 Description: See attachment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	567	$ 15,667	$	567	$ 15,667	1
2	Licensed Speech and Language Development Therapist		hrs		322	13,227		322	13,227	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		1,526	42,210		1,526	42,210	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		2935 hrs	29,587				2,935	29,587	8
9	Pharmacy		# of prescrpts		48	2,256		48	2,256	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 29,587	2,463	$ 73,360	$	5,398	$ 102,947	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Good Samaritan Care Center **#** 0011650 **Report Period Beginning:** 01/01/2000 **Ending:** 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2000 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 76,841	$	1
2	Cash-Patient Deposits	4,829		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (265,670))	384,923		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	24,467		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 491,060	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	3,531,812		14
15	Leasehold Improvements, at Historical Cost	25,220		15
16	Equipment, at Historical Cost	338,830		16
17	Accumulated Depreciation (book methods)	(1,066,943)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	13,915		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction Project	142,329		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,985,163	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,476,223	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 785,306	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,829		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	118,324		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,135		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Portion of Long Term Debt	517,750		36
37	Capitalized Equipment Lease	12,094		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,440,438	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,351,836		39
40	Mortgage Payable	298,930		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Restricted Gifts	74,271		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,725,037	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,165,475	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (689,252)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,476,223	$	48

***(See instructions.)**

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (645,754)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (645,754)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(43,498)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (43,498)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (689,252)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,546,579	1
2	Discounts and Allowances for all Levels	(1,370,171)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,176,408	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	213,873	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 213,873	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,103	12
13	Barber and Beauty Care	6,887	13
14	Non-Patient Meals	6,679	14
15	Telephone, Television and Radio	34	15
16	Rental of Facility Space		16
17	Sale of Drugs	46,391	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,661	19
20	Radiology and X-Ray	196	20
21	Other Medical Services	183	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 66,134	23
	D. Non-Operating Revenue		
24	Contributions	22,196	24
25	Interest and Other Investment Income***	2,207	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,403	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on Disposal of Property	42	28
28a	Legal settlement	431,239	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 431,281	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,912,099	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	584,131	31
32	Health Care	1,153,577	32
33	General Administration	768,089	33
	B. Capital Expense		
34	Ownership	358,526	34
	C. Ancillary Expense		
35	Special Cost Centers	39,668	35
36	Provider Participation Fee	51,606	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,955,597	40
41	**Income before Income Taxes (line 30 minus line 40)****	(43,498)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (43,498)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,080	$ 35,985	$ 17.30	1
2	Assistant Director of Nursing	904	2,809	21,731	7.74	2
3	Registered Nurses	12,456	11,142	169,105	15.18	3
4	Licensed Practical Nurses	16,457	17,471	183,101	10.48	4
5	Nurse Aides & Orderlies	44,932	48,207	366,265	7.60	5
6	Nurse Aide Trainees	16,081	16,827	88,007	5.23	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,701	1,903	14,474	7.61	9
10	Activity Assistants	1,548	1,548	8,665	5.60	10
11	Social Service Workers	3,517	4,112	48,084	11.69	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,080	26,013	12.51	13
14	Head Cook	6,377	6,743	41,522	6.16	14
15	Cook Helpers/Assistants	9,553	10,272	75,729	7.37	15
16	Dishwashers					16
17	Maintenance Workers	3,951	4,111	42,354	10.30	17
18	Housekeepers	9,097	9,522	52,083	5.47	18
19	Laundry	5,748	6,094	36,747	6.03	19
20	Administrator					20
21	Assistant Administrator	1,984	2,080	37,175	17.87	21
22	Other Administrative	1,392	1,536	57,799	37.63	22
23	Office Manager	1,965	2,080	22,521	10.83	23
24	Clerical	1,950	2,154	13,634	6.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,309	2,459	24,823	10.09	29
30	Habilitation Aides (DD Homes)	2,935	3,358	29,567	8.80	30
31	Medical Records	1,679	1,852	20,827	11.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	150,632	160,440	$ 1,416,211 *	$ 8.83	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	146	$ 5,101	Ln 1 Col 3	35
36	Medical Director	96	2,400	Ln 9 Col 3	36
37	Medical Records Consultant	48	1,350	Ln10Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	2,256	Ln 39 Col 3	39
40	Physical Therapy Consultant	1,526	42,210	Ln 10a Col 3	40
41	Occupational Therapy Consultant	557	15,667	Ln 10a Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	322	13,227	Ln 10a Col 3	43
44	Activity Consultant	18	1,440	Ln 11 Col 3	44
45	Social Service Consultant	18	1,440	Ln 12 Col 3	45
46	Other(specify) Barber/Beauty		6,887	Ln 40 Col 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,779	$ 91,978		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	56	$ 2,119	Ln 10 Col 3	50
51	Licensed Practical Nurses	104	2,920	Ln 10 Col 3	51
52	Nurse Aides	131	2,418	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	291	$ 7,457		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Glenda Frazine	Executive Director	0%	$ 37,175
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 37,175

B. Administrative - Other

Description	Amount
Revere Healthcare, LTD	$ 132,458
TOTAL (agree to Schedule V, line 17, col. 3)	$ 132,458
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Katten, Muchin & Zavis	Legal	$ 6,566
Denton & Kewler	Legal	117,162
Image Architects	Legal	6,824
Revere Healthcare	Legal	3,575
Crowe Chizek	Accounting	27,780
Miscellaneous Professional	Miscellaneous	2,678
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 164,585

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,671
Unemployment Compensation Insurance	
FICA Taxes	105,443
Employee Health Insurance	102,243
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,694
Hepatitis Inoculation	575
Unemployment Claims	9,000
Workers Comp Retro Adj.	4,763
TOTAL (agree to Schedule V, line 22, col.8)	$ 248,389

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,310
Health Care Worker Background Check	1,032
(Indicate # of checks performed)	
Dues	3,720
Subscriptions	276
Yellow Pages	1,983
Classifieds	
Licenses	305
Employee Relations	5,625
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(1,983)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,268

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 422
In-State Travel	1,506
Seminar Expense	2,677
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,605

**See instructions.

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Good Samaritan Care Center # 0011650 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Assoc. of Homes for the Aging $3,640**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? _____

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,347** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,606**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,100**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.